SAMPLE INVOICE

State of California-Managed Risk Medical Insurance Board

CONFIDENTIAL

The County Children's Health Initiative (C-CHIP) Monthly Financial Report

(This form is confidential in accordance with Government Code Section 6254)

Contract Number	Contract Period	Billing Month
	7/01/05 - 6/30/06	Jan-06

Organization name

Address

Contact Person

Phone number	Fax Number	E-mail Address
( )	( )	

Section A: Benefits	**Total Funds**	**Federal Share (XX%)**	**County Share (XX%)**
CAPITATION *(Attach monthly Enrollment Report)*			
a. Under age one *Number of Enrollees _____ times $_____ Capitation Rate*			
b. Age one through 18 years *Number of Enrollees _____ times $_____ Capitation Rate*			
Total Benefits (a through b)			
Section B: Adjustments			
ADJUSTMENTS TO PREVIOUSLY REPORTED INVOICES *(Must provide explanation/documentation)*			
a. Costs for first year infants			
b. Costs for age one through 18 years			
c. Costs for first year infants adjustments			
d. Costs for age out adjustments			
e. Costs for Other adjustments			
Total Adjustments (a through e)			
Section C: Family Contributions			
LESS FAMILY CONTRIBUTIONS *(Must provide explanation/documentation)*			
a. Contributions collected			
b. Less refunds issued			
Total Net Family Contributions (a through b)			
Section D: Administrative Costs			
a. State Administrative Costs			
b. Actual County Administrative Services (Subject to 10% Admin Cap)			
Total Administrative Costs (a through b)			
Section E: TOTAL COSTS - BILLING MONTH (Total of Sections A+B-C+D)			

State of California-Managed Risk Medical Insurance Board

CONFIDENTIAL

The County Children's Health Initiative (C-CHIP) Monthly Financial Report

(This form is confidential in accordance with Government Code Section 6254)

Contract Number	Contract Period	Billing Month
	7/01/05 - 6/30/06	Jan-06

County Share Payable to the CHIM fund (County Share of Section E) $

Total Funds Reimbursable to the County $

(Total Funds of Section E less State Administrative Costs of Section D)

Authorized Contractor's Signature	**Printed Name and Title**	**Date**

I certify these are federally eligible costs and the information provided is true and accurate to the best of my knowledge.

FOR STATE USE ONLY

☐ Full amount approved for payment in the amount of $ _____.

☐ Adjusted amount approved for payment in the amount of $_____. (Include explanation)

☐ Other: (Include explanation)

Reviewed By:	Date:
Reviewed By:	Date:
Approved By:	Date:

For Remittance Advice:

MANAGED RISK MEDICAL INSURANCE BOARD
INVOICE CODING SHEET

CONTRACT NUMBER: 04MP008
INVOICE MONTH Nov-01

State Fiscal Year	PCA	Index	Object	Amount
05/06	6300	9000	751	
Total Inovice				**$0.00**

Any questions regarding this invoice should be directed to Laura Duncanson at 445-3107 or lduncanson@mrmib.ca.gov.

SPECIAL HANDLING NOTES: